Medical Chronology

XXXXXXXXXXXXXXXXXXXXX

NAME, F, XX yo, DOB: XXX, Deceased: XXX

NAME was a resident of XXX on XXX when she was administered another resident's medicines by mistake, which included a dose of XXX. She was also administered her own regularly scheduled medicines at this time which included XXX. These drugs are contraindicated together as their combination can be lethally toxic, the effects of which exacerbated NAME pre-existing conditions.

Beginning early in the morning of XXX, NAME began to experience a drastic decline in condition including a critically slow heart rate and critically low blood pressure, along with complaints of difficulty breathing, nausea/vomiting, abdominal pain and general weakness. 911 was called and she was transported by emergent ambulance to the XXX ED where triage was completed.

The nurse who administered the incorrect medicine called the ED shortly after NAME arrived to inform them of the error and that the patient had incorrectly received a dose of XXX extended release. Treatment was enacted toward reversal of the toxicity with ineffectual results, the patient was intubated with an endotracheal tube and mechanical ventilation. XXX soon lost her pulse and CPR was required. Upon return of spontaneous circulation XXX was transferred to the ICU where she was stabilized but presented comatose and with poor lab results demonstrating irreparable major organ damage.

The following day, XXX, it was determined by the care team and family members, including the POA, that due to unpromising quality of life indicators, such as XXX, life supporting measures would be removed and care would switch to comfort measures only. XXX ultimately expired on XXX after X days in the hospital due to the combined drug toxicity of XXX.

Medical History:

Medical - XXX

Surgical - XXX

Allergies - XXX

Oral Medication List as of XXX per XXX:

XXX –

XXX –

XXX –

XXX –

XXX –

Synopsis of Pertinent Medical Encounters Leading to Detailed Events:

XXX had a history of XXX, XXX, XXX, and XXX. Her chronic XXX as well as surrounding hospitals beginning in XXX following multiple hospital visits for altered mental status and a general decline in condition. Medication non-compliance is noted as a causal element leading to XXX ongoing need for acute medical care and subsequent long term care needs, her XXXs/co-morbidities requiring critical attention to dosing amounts and scheduling to establish and maintain therapeutic value. Her XXX and XXX contributing frequently to her hospital admissions and rehab/long term stays.

Detailed Chronology of Events:

XXX - XXXXXXCXXXX

XXXX - XXXXXXXXXXXX

PR - Police Report

XXXX - XXX Hospital Medical Center Records

XXXX - Office of the Medical Examiner Report

Date/Time:	Event:	Reference/Attribution:
XXX	XXXX - seen by ED for xxx and xxx. Discharged to XXX with diagnoses of: XXX, XXX, XXX.	XXX, MD XXX, NP pg. 43-47 XXX
XXX	Admit to XXX	pg. 41 XXX
XXX	Admit to XXX for XXX	Dr. XXX, MD pg. 60 XXX
XXX	Readmit to XXX	pg. 59 XXX
XXX	Discharged from XXX to home health care	pg. 93 XXX

XXX	XXX resident Face Sheet Order Administration Records and Vital Signs viewed.	XXX, LPN pg. 2 XXX Audit Log
XXX	Resident Face Sheet viewed by Director of Nursing XXX.	XXX, DON pg. 3 XXX Audit Log
XXX	911 call placed and dispatch notified.	XXX, XXX pg.28 XXFD
XXX	Ambulance unit notified of Unconscious/Fainting/Near-Fainting patient at XXX, dispatched to facility.	XXX, XXX pg.28 XXFD
XXX	Ambulance at XXX.	XXX, XXX pg.29 XXXX
XXX	EMS assess patient, check temperature.	XXX, XXX pg.26 XXFD
XXX	EMS check XXX. Stroke scale performed by EMS with XXX.	XXX pg.26 XXFD
XXX	GCS test administered by EMS, patient within normal limits. **Vital Signs**: BP: XXX HR: XX O2: XX%	XXX pg.26 XXFD
XXX	EMS checks XXX	XXX pg.26 XXFD
XXX	Primary Impression of XXX noted by EMS crew.	XXX pg.26 XXX
XXX	XXX moved to stretcher and transferred to ambulance. Heart Rate noted to drop to 34 beats per minute.	XXX pg.26/28 XXXX